NO 10

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
TRANSITION AGE YOUTH SYSTEM OF CARE BUREAU

Blue Ribbon Commission Recommendations

RECOMMENDATIONS	RESPONSE
1) *The Board should issue a clear mandate that non-pharmacological interventions are best practice with children wherever feasible. The Board should work with the Juvenile Court to fully implement and measure compliance with this mandate.*	• Juvenile Court Mental Health Services (JCMHS) reviews over 10,000 psychotropic medication authorizations (PMA) requests annually. • JCMHS implemented the PMA in May 2013 to standardize and guide recommendations made to the Courts related to the appropriateness of psychotropic medication regimens for dependency youth. • PMAs are requested by the Courts and reviewed by an adolescent psychiatrist and a pharmacist. • JCMHS also provides consultation to judicial officers and dependency attorneys regarding the full array of mental health treatment, including non-pharmacological interventions, available to dependency youth. • Upon completion of a full assessment by JCMHS, a written report is provided to the Courts outlining recommendations for non-pharmacological interventions and, if appropriate, specific medication recommendations. • DMH is involved in ongoing projects to improve and systematize the way DMH, DCFS, and the Court communicate and exchange/access information related to the PMA process, including: i. Development of an electronic version of the Prescribing Physician's Statement – Attachment: JV-220(A) submission and review system, which will increase the efficiency and accuracy of the PMA process. ii. Coordinating with DCFS to systematize their submission process of ancillary information regarding the youth. iii. Granting JCMHS staff access to the Child Welfare Services/Case Management System (CWS/CMS) state system to be able to access previous pharmacological and non-pharmacological interventions in youth to better inform the current treatment plan. iv. Improving the availability of the youths' DCFS Health and Education Passport to community providers and JCMHS staff. • Efforts are underway to help ensure that psychiatrists who treat DCFS youth have a minimum level of training, experience, and qualifications.

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2) *As part of performance-based contracting, mental health treatments for teens and transitioning youth must incorporate trauma-focused assessments and treatments, developmental status, ethnicity, sexual identity, and vulnerability to self-harming behaviors.*	• DMH requires all directly-operated and contracted providers to deliver comprehensive assessments of all adolescents using protocols that incorporate State Medi-Cal requirements. • Summary of assessments currently utilized:

COMPONENT	MENTAL HEALTH ASSESSMENT		
	Adult Initial (MH 532)	Child/Adolescent Initial (MH 533)	Juvenile Justice Child/Adolescent (676)
Age	18+	6-17	6-17
Ethnicity	✓	✓	✓
Developmental Status	Not specifically asked	✓	✓
Trauma-focused	✓	✓	✓
Sexual Identity	Not specifically asked	✓*	Not specifically asked
Vulnerability to Self-harm	✓	✓	✓

✓Indicates item is included in assessment

*Developmental milestones

• In addition to these components, as a standard of clinical practice, all children and youth receiving services from DMH are assessed for the presence or risk of co-occurring substance use. DMH will evaluate current assessment instruments and make necessary revisions to ensure elements are captured; clinical staff will be trained on any revisions.

• Current strategies for addressing issues of trauma, sexual identity and vulnerability to self-harming behaviors, and recommendations for future initiatives are as follow:

i. *Trauma-Focused Treatments*: through the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Plan, DMH directly-operated and contracted providers have been trained to deliver an array of trauma-focused treatment interventions (including Trauma-Focused Cognitive Behavioral Therapy, Seeking Safety, and Crisis Oriented Recovery Services)

ii. *Sexual Identity*: The MHSA PEI stakeholder planning process recommended prioritizing services to Lesbian, Gay, Bisexual, and Transgender (LGBT) youth and young adults. During the past few years, DMH has implemented an outreach and psycho-education project to its provider community regarding appropriately serving LGBT TAY. DMH will enhance training opportunities that enable providers to effectively identify and address sexual identity issues among clients.

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	iii. *Self-Harming Behaviors*: DMH uses an array of tools and resources in our effort to better understand and reduce the risk of self-harming behaviors in adolescents and youth. Risk for self-harming behavior is assessed consistently throughout the course of treatment. Additionally, DMH has a rigorous suicide prevention program which includes designated staff conducting training to the mental health provider community, faith communities, and non-mental health community-based organizations. DMH is in the process of selecting a set of standardized tools, to accompany the mental health assessment forms that may more accurately determine the level of vulnerability of adolescents and transitioning youth to self-harming behaviors. When available, the provider community, other County departments, and appropriate community partners will be trained in their utilization.

3) *Children age five and under in the child welfare system must have access to age-appropriate mental health services.*	• DMH in collaboration with DCFS and other county departments and a large network of providers and partner agencies has provided prevention and early intervention services to the birth to five children who are in or at risk of entering the child welfare system. • Evidenced-based mental health practices specifically for children ages birth to five, especially those who have experienced trauma and/or at risk for psychosocial, emotional, and behavioral problems related to abuse, neglect and developmental delays have been provided. i. Nearly 200 legal entity provider sites are currently delivering Evidenced Based Practices to the children ages birth to five. ii. Examples of EBPs provided to birth to five children are: Child-Parent Psychotherapy, Incredible Years, Nurse-Family Partnership, Parent-Child Interaction Therapy, Trauma-Focused Cognitive Behavioral Therapy, Triple P (Positive Parenting Program) iii. Over 5,000 DCFS-involved children ages birth to five received an Evidenced Based Practice during FY2011-2012 and FY2012-2013. iv. The portion of Katie A. Class members who are children ages birth to five and have received mental health services has continued to increase each fiscal year (approximately 7,100 were served in FY2011-2012 and 7,860 were served in FY2012-2013). This includes an increasingly large number of infants and toddlers under age 3. v. DMH was awarded a five-year PCIT training grant by First 5 LA to increase the number and geographic diversity of qualified PCIT providers, deliver PCIT services to eligible children two to five years old and their parents/caregivers. DMH has collaborated with DCFS to identify focal populations of children in or at risk of entering foster care as well as parenting teens and their children. Since October 2012, the number of PCIT providers has increased significantly (up to 20 new PCIT providers each year) and over 500 DCFS-involved children and their parents/caregivers have participated in PCIT. • DMH has also been sponsoring meetings of the recent ICARE Steering Committee, a subgroup of the Infancy, Childhood, and Relationship Enrichment (ICARE) Network. This subgroup has been developing an LA County Prenatal to Five Training and Leadership Consortium (TLC). The goals of the consortium are to: i. Augment "pathways" and enhance opportunities for mental health providers to become Infant-Family and Early Childhood Mental Health (IECMH) specialists (including meeting the CA IFECMH "endorsement" requirements). DMH has contracted with USC University Center for Excellence in Developmental Disabilities-Children's Hospital Los Angeles (UCEDD-CHLA) to implement a Birth to Five Core Training Series that will ultimately enable 1,000 participants to receive training in the LA County DMH Birth to Five core competencies. Reflective Facilitation training will also be provided to over thirty clinical supervisors. ii. Establish an LA County Transdisciplinary Leadership Consortium that promotes capacity building in support of comprehensive systems of care within local Service Areas, Best Start LA communities, and "Health Neighborhoods" through cross-training for representatives from the early care and education, mental health, health care, developmental disability, and child welfare systems that can be supported through multiple funding streams.